The Federal Sector of American Medicine:

History & Services, Present and ?? Future

Galen Barbour, MD

Team Names

(by length)

Purple People Protectors

Medieval Barbers

Gandalf’s Gang

Diverseline

Executive

Archaic

7up!

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Objectives:

1. Understand the origins and current status of the two largest federal health care delivery systems: the MHS and the VHA.
2. Explain the origins of the Public Health Service and its growth and development in America.
3. Describe the historical setting for the initiation of Medicare and how that system functions in today's American health care.

The Military Health System:

Two components:

- Readiness
- Health Benefit
  - ✓ Active Duty personnel
  - ✓ Dependents

Early History

Active duty care present in wartime from antiquity (Including Colonial America) Frontier America had field care and post hospitals (larger facilities in cities.) U. S. Army: Washington, San Antonio, San Francisco

U. S. Navy: Brooklyn, Philadelphia, San Diego, Norfolk, San Fran.

Dependents treated on ‘space available’ Permission made permanent by Congress in 1889.

System unchanged until post-W W 2.

Post W W 2

Societal pressures increased to widen benefits

Private sector (business-driven) offered insurance, why not the MHS?

1943 Congress approved maternal and infant care for dependents (first entitlement for dependents).

1945 G.I. Bill allowed federal funding for more specialty training.

1947: Creation of the Department of Defense

1954 – Military Medicare is passed

1965 – Medicare & the Great Society (CHAMPUS/VA)

1970s – Costs escalate; Cong. ‘bailout’

1980 – Military build-up; businesses are ‘self- insuring’ (HMO style).

1982 – CHAMPUS Reform Initiatives (CRI)

1992 – TRICARE implemented as the MHS' MCO.

Some initial troubles (financial & otherwise)

Now equivalent to any large HMO.

Issues of today:

a. Cost – 'insurance' v. uncovered dependents; rising costs of pharmaceuticals, etc.

b. Quality – 'civilian std of care' v. bureaucracy

c. Access – cost containment efforts v. public desire for more

In 2002:

the MHS (USA, USN, USAF) operated:

465 MTFs world-wide

91 hospitals

374 clinics

And served approximately 8.5 million enrollees as “the only HMO that goes to war!”

The VA Health System:

Three components:

- Health
- Benefits
- Memorial Services

1990

Dept VA $43 billion appropriation

VHA $17 billion budget for:

172 hospitals (avg.... size 300 beds)

310 clinics

75 Nursing homes

27 domiciliaries

240,000 employees

1,000,000 discharges

24 million OPV

History . . . steeped in war

Colonial America

- statutory benefits established, 1636
- based on English tradition

Revolutionary War

Pension Law 1776 (Cont Congress)

March 4, 1789 (Const. Enacted)

War of 1812

History . . . steeped in war

- 1833 Philadelphia (U.S.Naval Asylum)
- 1851 Washington, D.C. (U.S. Soldier's & Airmen's Home)

Civil War

- 1865 National Home for Disabled Volunteer Soldiers

History . . . steeped in war

WWI

1914 War Risk Insurance Act

- first acceptance of federal responsibility for health and welfare of military conscripts

1919 Public Health Service

- operated a system of hospitals for WWI veterans

Post WWI

1930 Veterans Administration created by merging:

- Veterans Bureau,
- Bureau of Pensions &
- National Home for Disabled Volunteer Soldiers

(47 hospitals, 22,700 beds)

History . . . steeped in war

Post WW II

1944 “G.I Bill of Rights”

1945 Omar Bradley, VA Administrator

Paul Magnusson, M.D., CMD

- Memorandum #2
- Title 38 created.

1960’s-80’s: increased construction and research funding

Results:

- Many new hospitals
- Two Nobel laureates
- Pioneering efforts

CAT scanner, cardiac pacemaker, role of surgery in CAD, value of Rx in HBP, aging research, Seattle foot, etc.

1989 VA given Departmental status:
Name change:
From Veterans Administration (VA)
To Department of Veterans Affairs (VA)
composed of three parts:
VBA (few people, much money)
NCS (fewer people, little money)
VHA (most people, moderate money)

Missions

1.Provide compassionate, high quality health care to eligible veterans.

2. Provide education & training to physicians, nurses and others.

3. Conduct medical research

4. Support DoD in time of national emergency

Services

VBA - Home loans, G.I. Bill, pensions and benefits

NCS - Burial and memorials

VHA -

- In-patient care (4%)
  - M/S/P (4 levels)
- Outpatient care (12%)
  - Primary Care
  - Subspecialties
- LTC

Customers

26 million veterans eligible

10 million entitled **(SC, POW, IR, AO)**

> 50% SC < 50% SC

NSC (A,B,C)

12 months = 2.45 million SSNs ("10%")

24 months = 4.2 million SSNs ("40%")

Major Provider:

>50% SC: 64% inpat; 62% outpat care

Pensioners: 78% inpat; 93% outpat

Challenges of the 90s

Quality of Care

Cost effectiveness

Shift to Outpatient setting

Comparison to Mgd Care

Corporate culture

Changes:

1965-1989 District Management

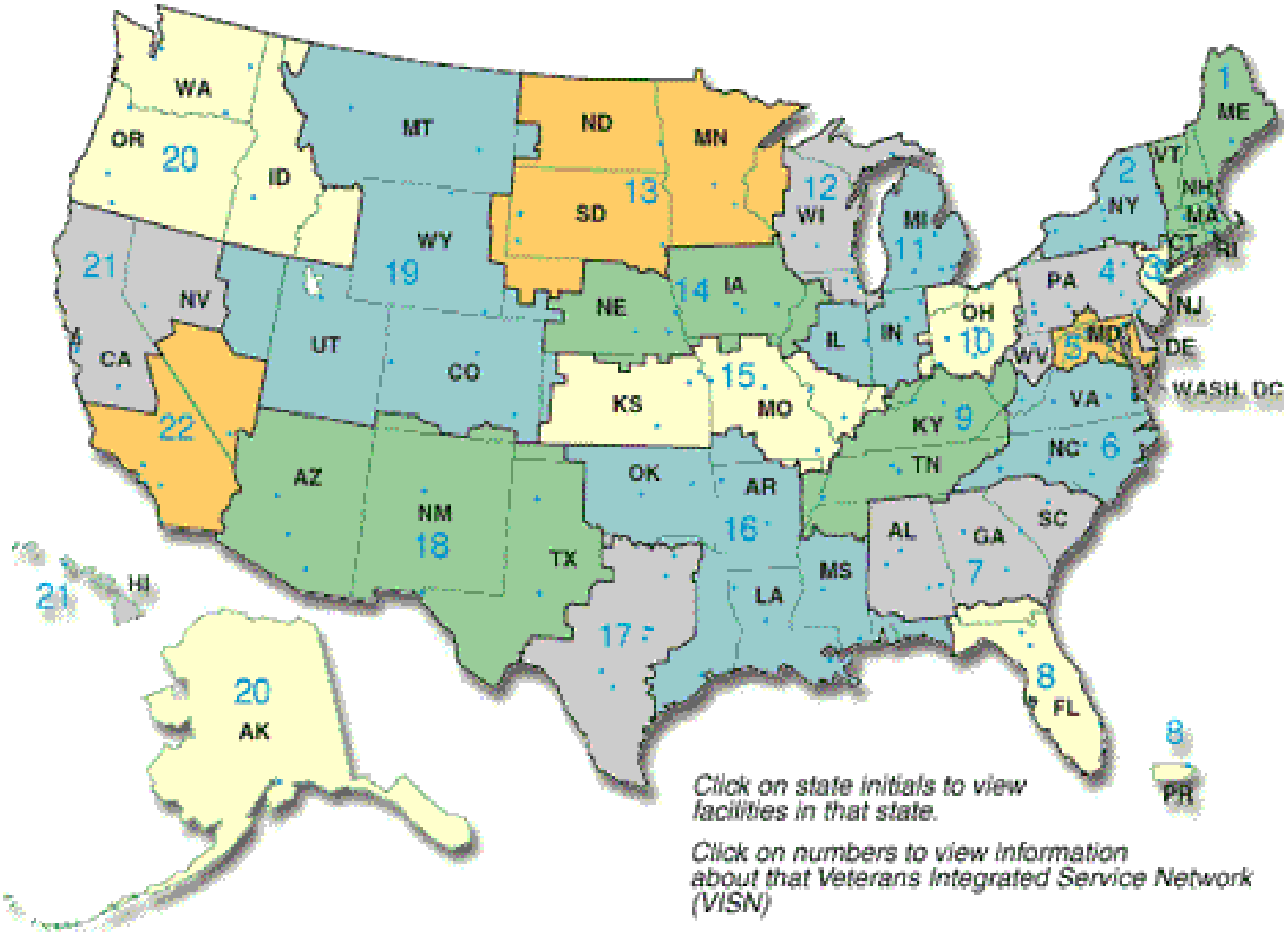
N=27; MC & Dist. shared director

1990-1996 Regional Management

N=4; 150 staff required

1996-2000 Network Management

N=22; 8 staff allowed; no shared directorships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Click on state initials to view facilities in that state.
Click on numbers to view information about that Veterans Integrated Service Network (VISN)

New Eval & Incentive System

Performance measures:

- **Clinical and administrative**
- **Multiple dimensions**
- **Initially oriented to structure, later to process and now to outcomes**
- **Tied to annual evaluations**

Results:

Benchmark level activity in prevention and care of patients with chronic conditions.

1990

VHA $17 billion annual budget for:

172 hospitals (avg... size 300 beds)

310 clinics

75 Nursing homes

27 domiciliaries

240,000 employees

1,000,000 discharges

24 million OPV

2002

VHA $18 billion annual budget for:

159 hospitals (avg... size 200 beds)

4000 clinics

75 Nursing homes

27 domiciliaries

190,000 employees

600,000 discharges

35 million OPV

Break !

The Public Health System:

The MEDICARE System:

History of Health Insurance

- 1850 -- Accidental Death Association of London: first company to pay for bodily injury that did NOT result in death
- 1850 -- Franklin Health Assurance Company of Massachusetts: medical expense coverage
- 1866 -- 60 companies offered health insurance

Birth of Modern Health

- 1929 -- Baylor Hospital, Dallas, TX
  - Room, Board, ancillary services for school teachers at a predetermined monthly cost

  → **BLUE CROSS** Plans
- Patients and hospitals were happy with these plans
- Coverage from Blue Cross DIRECTLY to hospital for set benefits

Group Health Insurance

- Started between the wars
- Particularly good when salaries were frozen
- Premiums were not subject to income tax or Social Security Tax
- Capitated, defined benefit programs still exist

Major Medical and Co-insurance

- Grew in the 1950's
  - Offered long-term catastrophic coverage,
  - companies began covering these with a deductible
  - Coinsurance was allowable

Medicare

Federal insurance program; Great Society

Beneficiaries:

- Over 65 years old
- Disabled (for more than 2 years)
- End Stage Renal Disease (came later than the other benefits)

Medicare

- Part A
  - Hospitals and facility fees
  - Nursing homes for acute, active treatment
  - Hospice care
- Part B
  - Physician bills
  - Supplies
  - Durable Medical Equipment

Medicare

- About 40,000,000 beneficiaries
- Initially, reimbursements were based on “Usual and Customary” charges
- Now pay on a fee schedule
  - 80% paid by Medicare
  - 20% “MediGap” or other
- There are non-covered services

Medicaid

- Title XIX of the Social Security Act
- medical assistance for those with low incomes and resources
- Federal AND State jointly provide costs.

Who Does Medicaid Serve?

1995

- 18.7 million children (doubled in 10 years);
- 7.6 million adults who care for these children;
- 4.4 million elderly; and
- 5.9 million blind and disabled.
- Others considered “medically needy”

ress http://www.hcfa.gov/pubforms/actuary/trendreport/200109/table2.htm Go Back Forward File

Table 2. Federal Medicare, Medicaid, and SCHIP Expenditures as of September 30, 2001

[in millions]

Trust Fund Expenditures	Total Medicare Expenditures	Federal Medicaid Expenditures	Federal F... Childre... ...ealth Insurance Program	Total Expenditures
This month	$19,831	$10,452	$290	$30,573
Fiscal year to date	242,353	129,374	3,699	375,426
Prior fiscal year to date	219,276	117,921	1,220	338,417
% Change	10.5	9.7	203.2	10.9

36 million

Note: State governments also support the Medicaid and SCHIP programs.

Highlights | Table 1 | **Table 2** | Figure 1 | Figure 2 | Figure 3

State role

- Establishes eligibility standards
- Determines type, amount, duration, and scope of services
- Sets the rate of payment for services
- Administers its own program

What services are covered?

Minimum set of services:

- hospital,
- physician and
- nursing home services.

Optional set of services (31 different ones):

- prescription drugs,
- hospice care, and
- personal care services.

Medicaid:

- is the largest insurer of long term care for all Americans, including the middle class.
  - Medicaid covers 68 percent of nursing home residents and over
  - 50 percent of nursing home costs.
- Medicaid covers skilled nursing facility care, intermediate care facilities for the mentally retarded and developmentally disabled, and home and community based-services.

Medicaid costs

- 2001 = $252 billion.
  - States = 43%
  - Feds = 57%
- The Federal government contributes 50% to 80% of the costs in each State's program, (varies by per capita).
- Average is $62700 per Medicaid eligible.

Medicaid:

- Covers medical care for 21% of children
- Covers costs of delivery for 34% of births
- Costs have risen about 10-11% annually (20% for pharmaceuticals)
- Costs total = $250 B

Summary

Federal health care covers half the insured population.

Federal health care delivers high quality outcomes.

America spends enough on health care to have universal coverage – but doesn't have it *because . . .*

Americans don't think federal health care is any good.